0.9(95%CI:0.7-1.1), with a mean increase in total length of stays per SRE of 16.4(95%CI:13.1-19.8), 11.4(95%CI:8.0-14.8), 10.9(95%CI:8.8-13.0), 13.4(95%CI:9.3-17.4) and 17.2(95%CI:13.6-20.7) days, respectively. For the same countries, the mean increase in number of outpatient visits per SRE were 3.8(95%CI:2.7-4.9), 4.7(95%CI:3.5-6.0), 1.1(95%CI:0.7-1.5), 1.3(95%CI:0.7-1.8) and 5.2(95%CI:4.0-6.5). Mean increase in number of procedures per SRE were 10.9(95%CI:9.5-12.2), 6.9(95%CI:5.6-8.2), 4.4(95%CI:3.7-5.0), 4.7(95%CI:3.9-5.6) and 10.1(95%CI:8.8-11.4). Data by SRE type show considerable HRU variation. **CONCLUSIONS:** Data indicate that SREs may result in a mean increase of 0.8–1.0 inpatient stays with a mean total duration of 10.9–17.2 days. SREs are also linked to numerous outpatient visits and procedures. Thus, a further reduction in the number of SREs by new bone-targeted agents should reduce the financial burden on European health care systems.

PCN118

CONSUMPTION OF ANTINEOPLASTIC AGENTS IN SLOVAK REPUBLIC WITHIN PERIOD OF 2006-2010

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OBJECTIVES: The main objective of this study was to evaluate the utilisation of antineoplastic agents in Slovak Republic during the period of 2006-2010. **METHODS:** Statistical analysed data including the number of medicine packages, DDD and financial expenditures were abstracted from the Slovak Institute of Drug Control. Key data were provided by wholesalers due to their legal obligation towards the SIDC. **RESULTS:** Consumption of antineoplastic agents in terms of DID (DDD/1000 inhabitants/day) reached its highest peak in 2007 with 31,12 and the lowest value of DID was observed in 2009 with 27,30. The total expenditures doubled their volume within period of 2006-2010 from 56,021,412 € to 111,646,240 € respectively. Number of delivered packages showed slight increase from 426,412 in 2009 to 629,782 in 2010 while price per single package was rising from 131,29 € (2006) to 197,68 € (2008) and then decreased to 177,28 € (2010). Resulting from further study the highest consumption in terms of DID was reached by gemcitabine (7,38 in 2006 and 7,21 in 2010), ifosfamide (5,91 in 2006 and 6,94 in 2010) and fourouracil (2,56 in 2006 and 3,26 in 2010). Expressed in financial units the most costly antineoplastic agent in 2006 was imatinibum with 8 569 021 €, followed by rituximab with 4,896,000 € and irinotecan with 4,888,660 €. In 2010 reached paramount financial consumption bevacizumab with 17,771,426 €, trastuzumab with 10,173,699 € and imatinibum with 8,212,353 €. **CONCLUSIONS:** Expenditures for antineoplastic agents are continually rising as a result of biological treatment establishment. There is observed significant increase of their consuption due rheumatic diseases treatment.

PCN119

LACK OF DATA FOR INDIRECT COSTS ASSOCIATED WITH TREATMENT OF EARLY BREAST CANCER

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OBJECTIVES: To review and analyse studies capturing indirect costs of treatment in EBC. Indirect costs can form a substantial part of the treatment cost and have a considerable impact on both the patient and society. **METHODS:** A literature review was conducted to identify publications that included indirect costs of EBC treatment. Indirect costs were defined as various out-of-pocket expenses or productivity losses. Medline, Embase, EmCare, Cochrane, NHSEED, HEED and EconLit databases were searched for published articles (January 2000 to November 2010), using pre-specified terms. A targeted internet search also captured publications from national websites in 10 countries. Indirect cost data were analysed to identify trends and a gap analysis was performed. **RESULTS:** Only 28 studies reported relevant data; they included data from economic models (based on thousands of patients), observational studies (including 22-324 patients), databases and surveys. The majority of studies reported indirect costs per patient; two studies reported cost to society, but rarely as part of total costs of EBC. Data collation and reporting was inconsistent across studies due to a variety of methods, definitions and outcomes, which made cross-comparisons difficult. Productivity losses and out-of-pocket costs were the most frequently reported outcomes (54% and 46% of studies, respectively). Mortality-associated costs were captured in 11% of studies. **CONCLUSIONS:** It was difficult to draw quantitative conclusions from the studies included in this review due to the paucity of studies, lack of standardisation and inconsistency in reporting of data. Reducing indirect costs would ease the financial burden to society, owing to the majority of patients being of working age. Identified cost data will be presented in the forthcoming poster; however, further work is required.

PCN120

THE NATURAL HISTORY OF FLUDARABINE-REFRACTORY CHRONIC LYMPHOCYTIC LEUKEMIA PATIENTS WHO FAIL ALEMTUZUMAB OR HAVE BULKY LYMPHADENOPATHY – A EUROPEAN PERSPECTIVE

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OBJECTIVES: To describe the current pattern of care and resource utilisation in Europe for patients with fludarabine-refractory chronic lymphocytic leukaemia (CLL) who are either refractory to alemtuzumab (DR) or ineligible for alemtuzumab due to bulky lymphadenopathy (BFR) **METHODS:** Medical charts were reviewed from nine sites in France, Germany, Italy, Spain and the UK. Patient charts with an index diagnosis of DR or BFR between January 2002 and June 2008 were abstracted, with a pre and post-index review period of 6 and 18 months respectively. **RESULTS:** Data are from an interim analysis of 37 patients, 62% (n=23) DR and 38% (n=14) BFR. Median time between first diagnosis and index refractory diagnosis was 5.2 years. Average age was 62.2 (range 41-77), 76% were male and average number of co-morbidities was 2.2. Many patients (59%) died during the post index period with median survival following diagnosis of refractory disease being 6.2 months. In the pre-index period the average number of pharmacotherapy regimens was 0.9 (range 0-3) and in the post-index period 1.4 (range 1-4). During the 24 month review period the most frequent single agent regimens were alemtuzumab (38% patients) and methylprednisolone (19%). Patients receiving combination therapy most frequently received rituximab (43%), mainly in combination with CHOP (16%), fludarabine/cyclophosphamide (11%), and bendamustine (8%). 89% of patients experienced at least one treatment related adverse event, including infection (76%), anaemia (76%), thrombocytopenia (68%) and neutropenia (62%). Average number of post-index A&E visits was 0.8 and inpatient stays 1.9, the majority (86%) relating to CLL or its treatment. Average inpatient stay was 11.2 days. Most patients (81%) had multiple diagnostic investigations (average 11.5), predominantly CT scans (average 6.1) and X-rays (average 2.0). **CONCLUSIONS:** This study demonstrates the high economic burden and continuing unmet clinical needs of patients with fludarabine-refractory CLL disease in Europe.

PCN121

CHALLENGES IN CONDUCTING PHARMACOECONOMIC ANALYSES IN CENTRAL AND EASTERN EUROPE – CASE STUDY ON BREAST CANCER

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OBJECTIVES: Health technology assessment (HTA) is rapidly developing in CEE countries as new technologies are difficult to finance with scare resources. Researchers often struggle with limited local epidemiologic and cost data. Therefore transferability of resource utilization from one to other markets is becoming an interesting topic. Late 2009 we conducted a study of advanced breast cancer in four CEE markets (Poland, Hungary, Slovak and Czech Republics). The project aimed to assess treatment sequence and resource used. **METHODS:** A common questionnaire was distributed to oncologists managing about 30 % of all oncology patients. The assessed periods of advanced breast cancer were: a) treatment initiation; b) routine follow-up on active treatment; c) pre-progression follow-up; and d) progression period. Data were extracted from hospital information systems and patient's charts retrospectively. Final results covered individual treatment/disease periods and total treatment course. **RESULTS:** Similar proportions of breast cancer patients precede to second-line treatment, we found differences in patients proceeding to third line treatment. In Czech about 67 % of treated completed 3 lines chemotherapy, in Poland it was about 30 %. In Czech and Slovakia taxane monotherapy represented the preferred first-line choice, Poland and Hungary favoured combination chemotherapy. We found differences across countries such as cancer care organization, guideline availability, number of oncologists. The above mentioned differences resulted in cost variations per patient from about 6 thousand USD (excluding chemotherapy) in Poland to 12 thousand USD in Hungary. Positions with highest relevance to cost differences were frequency and reimbursement of in-patient management and BS/palliative care. **CONCLUSIONS:** As cancer care organization, treatment algorithms and reimbursement for services differ, there is limited value in transferring cost data across CEE countries. The observed differences are especially relevant for cancer care where market access for new technologies might be un-equal in particular health care systems.

Cancer – Patient-Reported Outcomes & Preference-Based Studies

PCN122

DISCLOSING TRADITIONAL & COMPLEMENTARY MEDICINES (T&CM) USE TO THE HEALTH CARE PROVIDERS: A QUALITATIVE STUDY AMONG CANCER PATIENTS AT A LOCAL HOSPITAL IN MALAYSIA

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OBJECTIVES: This research study aimed to investigate the cancer patients' beliefs towards disclosing T&CM use to the health care provider. **METHODS:** Qualitative methodology was adapted to collect in-depth information with consented cancer patients. The participants were recruited from the oncology wards at Penang General Hospital from February till July 2010. Patients with different types of cancer and stages were recruited from the three major ethnic groups in Malaysia namely Malay, Chinese and Indians. Upon institutional ethical approval and informed consent from the participants, 20 semi-structured interviews were conducted. All interviews were audiotaped, transcribed verbatim and translated into English for thematic content analysis. **RESULTS:** Mixed beliefs were reported and a total of 4 themes were identified from the interview analysis: fear of termination of therapy by the physicians, fear of interaction with the orthodox medicines, perceived disinterest by the physicians and perception that T&CM are simple and its discussion to the physicians is irrelevant. Most of the patients agree that T&CM disclosure is important to avoid any interaction with the chemotherapy or radiotherapy. On the other hand, patients believe that T&CM discussion is not important due to the lack of physicians' knowledge & interest in discussing T&CM. A common perception regarding the simplicity in nature of some of the non-invasive traditional modalities such as prayers, spiritual & faith healing was reported as reasons of not disclosing T&CM use to the physicians. **CONCLUSIONS:** Understanding the underly-